Child Welfare Privatization: Synthesis of Research & Framework for Decision Makers

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PREFACE

There have been four major projects in recent years that have focused on management and finance and privatization changes occurring in state child welfare agencies across the nation—the Child Welfare League of America (CWLA) Finance & Contracting 50-State Surveys, the Health Care Reform Tracking Project, George Washington University's study of contracting practices, and the Children's Rights study.

Beginning in 1996, the *Child Welfare League of America (CWLA)* began to systematically identify, track, and describe child welfare *managed care* and privatized initiatives that changed management, finance, ad contracting in an attempt to stimulate better results for children and their families. Findings from 50-State surveys have been periodically published and disseminated. Since 1995, the *Health Care Reform Tracking Project* has been tracking publicly financed managed care initiatives – principally, Medicaid managed care reforms -- and their impact on children with mental health and substance abuse disorders and their families. A subset of those studies involve changes in the child welfare system. In 2002*, George Washington University (GWU)* completed an analysis of contracts and site visits in four states to examine how contracting for child welfare and behavioral health care services facilitated cross-system collaboration and service coordination. Finally, with funding from the Annie E. Casey Foundation, *Children's Rights* conducted an in-depth study of six privatized child welfare initiatives to examine the extent to which benefits are achieved by such projects and to determine what, if any, negative consequences occurred for children and families as a result of the privatized models. The report identifies themes that were common to many, if not all, of the initiatives and it provides specific recommendations for consideration by states or communities intending to use privatization.

This summary of national research distills findings from each of these and other privatization reports. The trends section is adapted primarily from a CWLA Issue Papers funded by the Center for Health Care Strategies[1] and from the Children's Rights report[2]. The framework for decision makers is adapted from an unpublished report prepared by McCullough & Associates (authors: Charlotte McCullough and Kathleen Penkert) for the Arizona Department of Economic Security (DES) in response to a legislative request for the department to weigh options for privatizing some or all portions of case management services. The report also includes lessons learned from executives of private agencies who have managed privatized contracts and who were interviewed as part of the Arizona project. Interviews were supplemented by primary source documents including Requests for Proposals (RFPs) and contracts. (Appendix 1 contains detailed descriptions of the case management models obtained through the interviews.)

The document contains two sections and an attachment. Part 1 contains an overview of the history of privatization, with a synthesis of research trends and findings and commentary on challenges, successes, and recent developments.

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PART I. NATIONAL TRENDS: A SYNTHESIS OF RESEARCH

This section places privatization in an historical context; defines elements that differentiate current efforts from traditional arrangements; and, provides a synthesis of research findings on the prevalence and types of privatization initiatives, including a discussion of key design features and changes that have occurred over time.[3] Examples are inserted to illustrate different aspects of various privatized models. The section concludes with commentary on challenges, opportunities, and recent developments.

1. The Evolution of Privatization

Although there is no single definition of privatization, the term generally has come to refer to a range of strategies that involve *the provision of publicly funded services and activities by non-governmental entities*.[4]

Even before the publicly funded child welfare safety net was developed, sectarian and non-sectarian agencies created and funded various services analogous to today's child protection, congregate care, and foster care services. Since the emergence of publicly funded child welfare in the 1880s, state and local governments have paid private, voluntary agencies to provide services.[5] Historically, relationships between private and public agencies were non-competitive quasi-grant arrangements, but over the past decade, public-private agency relationships have taken very different forms.

In the current environment, contracting (also called "outsourcing") is the most common form of privatization in the areas of child welfare, behavior health and juvenile justice. Unlike the former informal, noncompetitive arrangements between public agencies and nonprofit providers, today's contracts are typically awarded after a competitive procurement process.

The services that are privatized and the manner in which payment is made also have changed. Until the past decade, public agencies typically retained case management decisions and control over the types, amount, and duration of non-case management services that were delivered by the private sector. Under this traditional child welfare per diem or fee-for-service contracting model, the private agency simply agreed to provide placement or non-placement services to a certain number of children in return for payment based on a pre-determined daily or fee-for-service rate. The contractor was paid to deliver units of service and rarely was reimbursement linked to any measures of effectiveness of the services provided. Such a payment approach offered few incentives for service providers to control costs, to build a more suitable array of services as an alternative to placement, or to more quickly return children to their families. In fact, these contracts provided incentives to continue delivering more of the same service whether it was needed or not.

In recent years, over half of the state's public agencies have moved away from these traditional arrangements to a variety of risk or performance-based contracting options, often resulting in the contractor being given case management responsibility and greater flexibility and autonomy in determining how funds are used to meet the needs of individual children and families. The new

privatization models are varied, but certain features have characterized most of these efforts:

- Public agencies have shifted case management responsibilities to private agencies;
- Public agencies are more likely to purchase results rather than services; and,
- Financing mechanisms increasingly link implicit or explicit fiscal incentives to performance.

Privatization in child welfare takes many forms, with the respective roles of the public and private sectors varying, depending on the financial arrangements and the nature of the service that is being privatized. In addition to the term privatization, these reforms have been called a variety of names: public-private partnering, managed care in child welfare, community-based care, and results- or performance-based contracting. Regardless of the term, most of these initiatives have placed an increased emphasis on outcomes, or value for money spent, with a goal of getting improved results for the same or less money.

By most accounts, the privatization of child welfare services, especially case management, appears to be on the increase. Some observers argue that the trend has brought higher quality and greater efficiency, but others have raised concerns about its appropriateness. Still others contend that the essential issue is not whether but how privatization should be accomplished. While the federal government does have a policy indicating that inherently government functions should not be contracted out[6] federal law has not addressed the nature of state public agency/private agency child welfare contracts. Instead, child welfare public-private contracting has been governed by state law and regulation.[7] The ACF/Children's Bureau recently awarded funding to support a Quality Improvement Center on Child Welfare Privatization with the intent of building the knowledge base about effective privatization practices, particularly in relation to adoption services, that may result in improved outcomes for children and families.

There are abundant sources of information about child welfare privatization. There have been periodic national or targeted surveys of public administrators conducted to collect both quantitative and qualitative information on the types and prevalence of changes; identify barriers and any perceived or actual successes; track trends over time and identify emerging issues; and report and disseminate findings, often including recommendations for change.[8]

Other researchers have used case studies to look in-depth at one or more initiatives. Case studies have used combinations of document review and data analysis, phone interviews, and site visits. One of the most thorough and recent efforts to advance understanding of the current use of privatization, including the extent to which privatization achieved benefits or resulted in unintended consequences, was completed by Madelyn Freundlich of Children's Rights. Freundlich accomplished this in three ways: 1) by describing the concept and purported purposes of privatization; 2) using a case study approach to look at six different jurisdictions; and, 3) synthesizing the lessons learned and offering guidance to communities embarking on privatization.[9]

Detailed information on individual initiatives is found in independent evaluations (including evaluations of the two most comprehensive, statewide privatized systems, Kansas[10] and the University of South Florida's evaluation of Community-Based Care in Florida).[11] According to the last CWLA management, finance, and contracting survey, over half of the 39 initiatives described

in the report were planning, in the midst of, or had completed independent evaluations. One of the most comprehensive was the evaluation of Colorado's pilot capped allocation projects.[12]

2. National Trends

For nearly a decade, the Child Welfare League of America (CWLA) conducted periodic surveys of all 50 states and the District of Columbia (and a number of counties) and published findings related to the types of changes, if any, public agencies were making in how they managed, financed, or contracted for services. Survey responses were often supplemented by documents provided by the public agency respondents, including planning documents, RFPs, contracts, and evaluation studies.

The last published report in 2003 was based on responses from 45 states and the District of Columbia obtained in 2000-2001. The reports provided detailed profiles and aggregate analysis of 39 initiatives from 25 states.[13]

Broad Goals & Impetus for Change

In all of the CWLA surveys, public agency respondents described overarching goals that related to legal mandates of safety, permanency, and well-being. Many also cited goals related to increasing accountability or purchasing results. Since the introduction of the federal reviews, the Child and Family Service Reviews (CFSRs), it seems likely that as states weigh privatization options, they will introduce initiatives that respond to CFSR findings and link privatization efforts to the State's Program Improvement Plans. A range of factors has motivated privatization initiatives. Some were made possible by the Title IV-E waiver program that allowed states more flexibility in how they spent federal funds. Others were a direct result of lawsuits, settlement agreements, or an overall negative public perception of how the public child welfare agency was performing. Increasingly, initiatives appear to be driven by legislative mandates (41% of the CWLA initiatives). No state has a broader legislative

Impetus for Change

Kansas' statewide initiative was implemented as a result of a lawsuit as well as pressure from the governor and legislature to privatize services.

The performance-based contract reform in the District of Columbia is part of the federal court settlement agreement that allowed the public agency to emerge from receivership.

Most recently, in 2005, the Texas legislature passed a bill requiring the public agency to develop and gradually implement a plan for privatizing foster care, adoption, and case management services for children requiring out-of-home care (SB6).

Legislative Mandates in Florida

In 1996, the Florida Legislature mandated four pilot programs that privatized child welfare services through contracts with community-based agencies.

In 1998, HB 3217 mandated statewide privatization of all foster care and related services. Related services included family preservation, independent living, emergency shelter, residential group care, therapeutic foster care, intensive residential treatment, case management, post-placement supervision, adoption, and reunification.

Child protective service intake and investigations remain in the public sector to be managed by DCF or by the sheriff's departments.

mandate than Florida.

The Scope

Most privatization initiatives are limited to a particular region of a state or a subgroup of the child welfare population. Some initiatives are small, contained pilots that stay small. Others eventually expand. A few projects from the onset were intended to cover most or all of the statewide child welfare caseload. Florida and Kansas are the two best-known examples of the latter.

The Range of Privatized Services

Services included in the 39 initiatives described by CWLA varied depending on the target population.

The Hotline function and the initial child protective services (CPS) investigation were retained by the public child welfare agency (or in some locales by law enforcement) in all of the 39 initiatives. Beyond those initial intake and investigation functions, however, the full range of child welfare services has been the focus of different privatization initiatives.

Arizona is the most recent but not the only State exploring privatization of case management services. In fact, case management services were the most likely services to be included in the initiatives reported by CWLA. Each initiative defined case management services in its RFP or contract with great variation among initiatives. In some initiatives, private agencies have assumed some or all of the core case management functions from the time of referral until the achievement of permanency.

Finding

In the last CWLA survey, the most likely service to be included in a privatization initiative was case management (or care coordination), with over half of the initiatives including the privatization of case management.

The responsibilities of the private agency might include placement and service delivery functions in addition to case management. In Florida, for example, the private community-based lead agency receives the case during the investigation when it becomes clear that ongoing services (either in-home or placement services) are needed during or post-investigation, and the lead agency retains the case until the case is closed. Case management is privatized for all children post-investigation regardless of whether the child is served in-home or out-of-home and whether services are provided under court supervision or under voluntary services. The private agencies work with families to develop and implement the case plan and set permanency goals; manage court related processes; make placement and discharge decisions; and recruit, train and support foster and adoptive families.

In many states, case management is fully or partially privatized only for a defined subset of the child welfare caseload, again with great variation. In some states, the focus of the privatized case management agency is on diverting low-risk children from the formal child welfare system during or following the investigation that is conducted by the public protective service worker (or, in some jurisdictions, by the sheriff's department). Arizona's Family Builders was an early

example of an early intervention model. More recently, in 2005, Iowa launched a similar community diversion initiative for children and families in need of services (but not an open CPS case) to be served by community-based providers. Under that model, the public agency retains case management for all other cases.

In other states, the emphasis has been on privatizing case management and services for children at the deep-end of the system, usually those who present with complex needs and require placement in therapeutic levels of care. Many of the early models tracked by CWLA were focused on that small percent of cases that consumed a disproportionate share of resources. The rationale was that if children with complex needs could be better managed and stepped down or out of the system sooner, more children could be served for the same or fewer resources. Some efforts were more successful than others in achieving this goal. The *Commonworks* initiative in Massachusetts is an example of a successful effort. For nearly a decade, a portion of the State's children in need of residential care were referred to private agencies who coordinated care and provided or purchased services from other community providers. In this dual case management model, the public agency caseworkers retained final decision-making in terms of permanency goals and other key decisions, working in tandem with private case managers. (Appendix 1 contains more detail on *Commonworks* and an interview with a lead agency executive who describes the recent dismantling of *Commonworks* as part of the launch of a new initiative, thoughts on dual case management systems, and the lessons learned).

In some initiatives, children with complex service needs who are served by multiple public agencies are the focus of the privatization effort. Cross-system funds are blended to support a coordinated case management and service delivery system. The Missouri Interdepartmental Initiative is a good example of this approach. In that model, a private agency was given total case management responsibility for a limited number of children referred in a specific region of the state. (Appendix 1 contains a description of the initiative and an interview with the lead agency executive).

Some states have privatized case management for children in need of traditional foster care or home of relative care. The performance-based contracts in Illinois and Michigan described later in this section provide examples of how States aligned payments with desired results in specific program areas.

Many states have privatized case management for children with adoption as a permanency goal -- with variation in the time the transfer of case management occurs (pre-or post termination of parental rights) and in the financing mechanism. Michigan was one of the earliest States to structure its payments to private agencies to reward timely achievement of adoptions with payments decreasing the longer the agency worked to find and place a child with an adoptive family. (See Appendix 1 for examples of privatized adoption contract provisions from Massachusetts and Kansas).

With few exceptions, initiatives that privatized case management also have included the provision or management of many other services in addition to case management. For example, an agency responsible for case management might also be responsible for providing in-home and out-of-home care placement services, recruiting and licensing foster families, and providing pre- and post adoption services.

As noted in the examples, the degree of public agency involvement and ultimate authority in case management decisions has varied from one initiative to another. In some states, the public agency has delegated virtually all control to the private contractor (See Florida, for example, in Appendix 1). In other initiatives, the private agency has control over certain decisions but the public agency retains control and requires prior notification for significant milestones and has veto power over key decisions.

When private agencies assume responsibility for core functions, the public agency retains responsibility for oversight. The public agency must set the standards, define the outcomes and performance expectations, and then monitor performance through contract monitoring and quality assurance and improvement activities.

Structural Designs

There is no one "business model" or structural design for privatization that has been proven to be superior to another. When public agencies contract for case management and other services, they typically rely upon private, nonprofit contractors. Fewer than 10% of the initiatives described by CWLA, for example, contracted with for-profit entities.

CWLA reported the majority of initiatives are using a lead agency model (51%) supported by a provider network or other collaborative service delivery arrangement. The lead agency model is what is being used under Florida's Community-Based Care plan and the Kansas privatization model. Under this type of arrangement, the public agency contracts with one or more agencies within a designated region to provide or purchase services for the target population from the time of referral under the obligation ends -- often at case closure. Some lead agencies provide most, if not all, services with few or no subcontracts. Others may procure most

Lead Agency Responsibilities in Florida

In the last five years Florida has transitioned to a community-based child welfare system. The Department has contracted with 22 regionally defined lead agencies and each must have the capacity to:

- Develop a comprehensive array of in-home, community-based, and out-of-home care options through a provider network;
- Manage the funds and address cost overruns;
- Provide or subcontract for the direct provision of all services needed by all children referred by the PI: in-home services, foster or kinship care, adoption, Independent Living;
- Approve, review, authorize, and pay provider's claims;
- Design and implement a comprehensive, individualized case management system;
- Develop 24/7 intake and referral capacity;
- Ensure child & family involvement and satisfaction at all levels of case management and service delivery;
- Handle all court-related processes;
- Establish a quality assurance system to ensure continuous improvement;
- Meet all specified safety, permanency, and well-being outcomes and system performance indicators as required by the contracts; and,
- Gather and report all information required for quality and performance oversight.

services from other community-based agencies and directly provide case management and/or limited services. Some contracts impose a cap on the services that the lead agency can deliver if it assumes case management.

Finding

In all of its various forms the lead agency model has been the most common in child welfare privatization.

Some lead agencies are single agencies that have long histories as child welfare service providers, while others are newly formed corporations that were created by several private agencies for the sole purpose of responding to the contract opportunity. A few lead agencies were created through collaboration between nonprofit agencies and one or more for-profit organizations.

Performance-based contracts between the public agency and private providers are found in nearly a quarter of the CWLA initiatives. In this model, either payment amounts or schedules are linked in new ways to performance or achievement of certain case milestones, or the providers are given case rates for certain populations and expected to achieve specified results.

Performance-Based Contracting in Michigan

Michigan began the Foster Care Permanency Initiative as a pilot project in 1997 in Wayne County (Detroit). The goals were to reduce the length of stay in foster care and increase the numbers of children who achieved permanency within the specified time frames.

The planners created the funding structure to provide foster care providers with flexibility. The principal design is a reduced per diem rate and a reallocation of the resulting savings into three lump sum incentive payments tied to performance goals.

There are few strings attached to the lump sum payment—allowing providers to purchase or provide whatever services or supports are needed to achieve the results.

Lump sums are paid at designated milestones of each case——an initial referral payment, a performance payment, and a sustainment payment. The daily rates and the incentive amounts have changed multiple times since the project was first launched.

Illinois was among the first states to implement performance contracts for kinship and foster care providers. In FY 2000, slightly more than 21,000 children were served statewide using performance contracts. This shift was accomplished by redesigning how new children are referred to foster care agencies for placement. Performance contracting (initially implemented only in Cook County), requires all agencies to accept an agreed upon number of new referrals each month with the expectation that a certain number of children in care would exit care to permanency each month. Falling short of target percent of children exiting care means serving more children without additional funds. In Illinois, agencies must absorb the costs of any uncompensated care. If the number of children in excess of the payment level exceeds 20% of the number served, the agency risks the loss of the contract. By exceeding the benchmark in permanency expectations, an agency can reduce the number of children served without a loss in revenue. Agencies also receive $2,000 for each child moved to a permanent placement beyond the contract requirement.

Public agencies are increasingly using performance-based contracts with both lead agencies and with single providers. In some instances the performance-based trend is a direct result of legislative action or litigation. In Iowa, for example, the *Better Results for Kids Initiative* calls for the State to move towards performance-based contracts with all service providers. Similarly, for the past three years, the District of Columbia has been transitioning to performance-based contracts for the requisition of all services as a requirement of its settlement agreement approved by the federal court.

Quality, Accountability & Performance Expectations

Regardless of the structural model, public agencies are focused on improving quality—with all initiatives including some methods to collect and manage utilization, quality, outcomes, and fiscal data. Perhaps the most important change with privatization relates to what gets monitored. In many traditional child welfare programs, monitoring mechanisms, to the degree that they existed, focused almost exclusively on process issues, i.e., were certain tasks performed (assessments, number of visits, therapy sessions, etc.). The new initiatives are part of a broader trend that seeks to follow client outcomes in addition to or instead of process indicators.

Finding:

There is a premium placed on data collection to support QA/QI and contract monitoring but there is also evidence that many current automated systems may not be up to the task.

Most initiatives specify performance standards, improved functioning indicators, and client satisfaction requirements in their Requests for Proposals (RFPs) and their contracts. Specific outcome measures vary according to the target population served by the initiative but initiatives are most likely to include indicators related to child safety, recidivism/reentry, and achievement of permanency within the timeframes required by the Adoption and Safe Families Act (ASFA).

States and counties use multiple methods to collect and manage data on their privatization initiatives. Many plans appear to rely heavily on reports generated by the contractor or from the State's automated MIS. However, both the findings of the independent evaluators and the responses to the 2001 CWLA survey indicate that data collection and management remain challenges for public and private agencies across the county.

The CWLA survey also asked whether the Statewide Automated Child Welfare Information systems (SACWISs) were used to collect and report cost, outcomes, and utilization data for the initiatives described. Twenty-eight respondents (71.8%) answered this question, and of those, only five (17.9%) stated that they were using SACWIS for the initiative. Many others indicted that they had plans to adapt their SACWIS to collect this type of information.

Respondents also were asked whether their state or county had the ability to track the overall effect of the child welfare initiative on other child-serving systems. Only four of the initiatives reported this capability. The lack of ability to track utilization, costs, and outcomes for children and their families across child-serving systems is problematic. There is also a gap between information that is tracked and information that is actually used for system planning and improvement. Child welfare initiatives appear to have difficulty generating data in a form and in a time period that is relevant and helpful for planning and decision-making.

In addition to data obtained from the MIS and standardized assessments, states and counties reportedly use a variety of approaches to monitor performance. Frequently cited methods for collecting outcome and performance information include:

- Reviewing quarterly reports,
- Reviewing case records,
- Using quality assurance protocols,
- Using monthly problem-solving meetings,
- Making scheduled and unscheduled site visits,
- Reviewing disrupted placements and critical incidents, and
- Conducting independent evaluations.

Funding Sources

The bulk of federal child welfare funding is disproportionately directed toward out-of-home care—the very part of the system that public agencies are seeking to minimize. Given the complexity of child and family needs and the inadequacy of child welfare funds to support preventive, home-and community-based care, and therapeutic services, child welfare agencies have traditionally tapped other federal, state, or local funds. Each funding source may come with different program eligibility and match requirements.

As child welfare agencies strive to rearrange fiscal relationships, payment mechanisms, and introduce risk based contracting, they have to also ensure that the proposed changes will not negatively affect their ability to access funds from sources outside child welfare or to maximize federal revenues. To accomplish these goals, some States have operated under a Title IV-E waiver allowing the state to spend Title IV-E funds on a range of alternatives to foster care as long as the overall expenditures are cost-neutral to the federal government. Other States have attempted to maximize federal revenue and gain greater flexibility over limited dollars by changing the funding mix—combining child welfare, TANF, Medicaid, and behavioral health block

An Integrated System of Care

Wraparound Milwaukee has been in existence since 1995. Wraparound currently serves about 1000 children who have serious emotional disorders and who are identified by the child welfare or juvenile justice system as being at risk for residential placement; children with behavioral health problems who are referred by child protective services who have not yet been removed from home; and, a population of mothers (and their children) who are involved with the substance abuse, welfare-to-work and child welfare systems.

A combination of federal, state, and county funds is used to finance the system. A pooled fund is managed by Wraparound Milwaukee, housed within the Milwaukee County Mental Health Division, which acts as a public care management entity. Wraparound Milwaukee utilizes managed care technologies, including a management information system designed specifically for Wraparound Milwaukee, capitation and case rate financing, service authorization mechanisms, provider network development and utilization management, in addition to coordinated care management, provided by private agencies.

The overall reduction in expenditures from 1996 to 2000 has resulted in $8.3 million in savings for the County.

grant dollars in new ways to support children and families involved with the child welfare system. When multiple funding sources are used, the child welfare agency has had to reach agreement across child serving agencies on how funds will be included in the child welfare contract or made available to the child welfare contractor or public agency by some other means.

Finding

The core funding reported for the child welfare initiatives comes primarily from child welfare sources, but the vast majority of initiatives (72%) are supported by other funds, particularly Medicaid and mental health.

The 2001 CWLA survey explored the sources of funds used by child welfare agencies to support their child welfare initiatives. Most initiatives were supported by diverse funding sources. For example, of the 36 initiatives that identified funding sources, 26 of them (72%) reported using funding from outside the child welfare system. Consistent with findings in 1998, Medicaid and mental health funds were the most likely sources of funds to be used in combination with child welfare funds to support the initiatives. The use of TANF funds was on the increase. In 1998, less than 17% of the initiatives included TANF funds, compared to 30.6% in 2001. There is, however, a continuing downward trend related to the use of substance abuse and education funds in these initiatives. In 2001, only 11.1% of the child welfare initiatives reported that they used substance abuse funds, despite the need for access to early intervention and treatment services, especially for the parents of children served by the child welfare system. This level is a slight decrease from the 1998 finding, in which 13% of the initiatives reported using substance abuse funds. Education funds were the least likely funds to be used in the initiatives.

There was a slight increase in 2001 in the number of initiatives that were described as Integrated Systems of Care projects. In many instances, projects were initiated with various federal and foundation planning funds with the explicit purpose of integrating services across public systems, maximizing federal revenue, and creating seamless and flexible systems for children served by public agencies. Many of these new models are publicly managed but with innovative privatized contract arrangements that also create incentives at the service level.

Risk-Based Financing Options

As in previous years, the CWLA 2001 survey revealed significant variations in financing arrangements among the child welfare initiatives. The arrangements may even vary within the same initiative over time or between different county initiatives within the same state. The level of risk ranges from global budget transfers, to capped allocations or capitation, to case rates, to discounted Fee-For-Service or per diem arrangements that include bonuses and/or penalties based upon performance or case milestones.

Finding

Over 90% of the child welfare initiatives include changes in financing or payment practices to create incentives for performance. Many initiatives include more than one mechanism to align payment with desired results.

Each of these options, as it is typically used in child welfare, is described below.

Capitation, Capped Allocations, & Global Budgets

In the purest managed care financing model, a contractor is prepaid a fixed amount for all contracted services for a defined, enrolled population on a monthly basis. This per member, per month, population-based payment arrangement is referred to as capitation. In this type of arrangement, the contractor is at risk both for the number of children who use services and for the level or amount of services used. The contractor receives the predetermined amount based on the number of enrolled children regardless of the number of children who actually use services or the level of services that enrolled children require during the month. If the contractor enrolls children who subsequently underutilize services, the contractor will make a profit. Conversely, the contractor is exposed to significant financial risks if the plan is not adequately priced or if the eligible enrolled population uses more services or more costly services than projected.

There are a number of reasons cited by child welfare administrators for not extensively using pure capitation models in child welfare. Part of the challenge has been the lack of accurate data that can be used in an actuarial model to project for the general population what percent will require services from the child welfare system, at what level, for what period of time, and at what cost. Another serious challenge is the relatively small number of children who will be enrolled as compared, for example, to covered lives under a public sector managed health care plan, making capitation for child welfare very risky.

Several public agency child welfare initiatives include reimbursement methods that resemble capitation. For example, in many of the county-administered initiatives, the state provides the county a capped allocation, and the county assumes responsibility for managing and delivering (or purchasing) child welfare services under this block grant. Under such arrangements, the county agency is often also given increased flexibility and control over resources and the ability to retain savings. The county agency may decide to share risks and case management responsibilities with individual service providers or lead

Florida's Global Budget Transfer

The Department of Children & Families (DCF) contracts with twenty-two lead agencies for a fixed dollar amount that approximates the appropriation that district offices previously received to provide all child welfare services with the exception of investigations and the Hotline. Lead agencies are expected to access other funding sources, such as Medicaid for therapeutic services and local funding for prevention. In addition to the funds to support services, DCF transferred administrative and management resources (including capital equipment) to the lead agency based on a calculation of the pro-rata share of public agency positions eliminated as a result of privatization.

Prior to the introduction of lead agency contracts, DCF acknowledged that fiscal inequities existed in its methodology for allocating funds, which resulted in greater allocations to districts that had higher placement rates and longer lengths of stay. Over time, DCF has attempted to more equitably distribute funds and reward performance related to permanency, safety and well-being. Equitable funding is not yet fully evident, resulting in some lead agencies getting higher levels of funding than others.

When fully implemented, there will be over $400 million in contracts with lead agencies.

agencies.

There are also several lead agency models that include financing arrangements that resemble capitation. In Florida, nonprofit lead agencies operate under a global budget transfer. They are given a predetermined percentage of the state's annual operating budget and asked to provide all services, in whatever amount needed, regardless of how many children and families in their geographic area may require services. The allocation is based in part on historic caseload size and previous spending for the geographic area covered and in part on assumptions of how the new privatized community-based care systems will affect future utilization patterns and outcomes.

Case Rates

Finding

The most common risk-based model in child welfare is a case rate.

Under this arrangement, a service provider, private lead agency, or other managed care entity (MCE) is paid a predetermined amount for each child referred. The contractor is not at risk for the number of children who will use services but is at risk for the amount or level of services used. For the contractor, if the case rate amount is adequate, it is a *less risky* financing arrangement than capitation.

In child welfare contracts, the case rate could be episodic or annual. An episodic rate means the contractor must provide all the services from initial entry into the plan until the episode ends. The point at which payments stop and risk ends varies from one initiative to another. However, it is common for the contractor to bear some risk until specified goals are achieved, whether it takes days, weeks, or years. For example, a typical case rate contract for foster care services might extend financial risks for up to 12 months after a child leaves the foster care system. If a child reenters care during that time, the contractor may be responsible for a portion (or all) of the cost of placement services.

Under an annual case rate, the provider receives the case rate amount each year the child is in the child welfare system and the contract is in effect. In both annual and episodic case rate arrangements, the payment schedule could be a monthly per child amount or it could be divided into lump sum payments that could be linked to

Episode of Care Case Rates

The Cuyahoga County, OH child welfare agency uses an episode of care case rate in a pilot that targets a portion of the county's caseload of children, from birth to age 14, who are in specialized foster care or higher levels of care. Only children who have behavioral or health care needs and their siblings are in the pilot. The case rate amount ($50-53,000) was established through an RFP process.

The case rate is designed to cover the period of custody to permanency, plus 9 months (12 months for children who are adopted) and assumes that at least 50% of children achieve permanency within 12 months.

The payment schedule for contractors calls for 18 equal monthly payments for each child/family. The payments are made whether the child remains in care the entire 18 months or longer or achieves permanency sooner. If the child achieves permanency and remains stable for nine months, the financial obligation of the contractor ends. If the child reenters care within nine months of permanency, the contractor must take responsibility for the child's care and services within the original case rate.

attainment of various outcomes. An episode of care case rate is far riskier for the contractor than an annual case rate due to the many factors outside of the contractor's control that may extend the time it takes for the episode to end.

Bonuses and Penalties

As noted with the performance-based contract description, more public agencies appear to be aligning payment schedules and/or payment amounts to outcomes or results.

A number of states with fee-for-service arrangements, case rates, or other financing arrangements are also adding bonuses and penalties based on performance. Initiatives differ widely in the selection of performance measures and in the incentives that are provided. Some initiatives include only bonuses; in others, only penalties; and in yet others, both bonuses and penalties.

A number of other states and counties are experimenting with bonuses, penalties, or both that are added to case rate payments if the provider meets expectations.

Mechanisms Used to Limit Risks and Savings/Profits

Before examining the mechanisms used to limit risks, it is necessary to understand what the risks are. Every fiscal strategy, even a traditional fee for service arrangement, has risks -- the potential for revenues and expenditures to vary. When revenues exceed expenditures, there is a surplus, which can be taken as profit or reinvested in the system. When expenditures exceed revenues, there is a loss. The risks can be found in the number of children who use services, the unit costs, the case mix, the volume, and the duration. Risk-sharing is a function of determining who is responsible for each type of risk. There are different inherent risks associated with each of the previously described risk-based financing options.

Bonuses and Penalties

Cuyahoga County, OH includes penalties but not bonuses in its lead agency contracts. The lead agencies serving children ages 14 and younger must achieve permanency within 36 months for 80% of the children served.

The lead agency serving children 12 and younger must achieve permanency within 36 months for 87% of children served. For every child over the allowable standard who has not achieved permanency, the provider will be fined $3,600.

Ohio Risk and Reward Corridors

In the Cuyahoga County case rate pilot, one contractor has accepted full risk, and the other two have a 10% risk corridor. There are limits on how All contractors use potential retained savings.

In Franklin County, lead agencies are protected from excessive financial risk through the establishment of a stop loss that will pay 50% of direct service costs if total costs for an individual child exceed four times the case rate. The contract also includes risk-reward corridors that prevent lead agencies from gaining or losing more than a set percentage each year. In the first year, the risk corridor was 10% of the total budget, in the second year it was 15%, and in the third year it was 20%.

In the Hamilton County Creative Connections initiative, the arrangement in 2000 with the lead agency included both individual and aggregate stop-loss provisions.

Because of the newness of risk-based contracting, the uncertainty in calculating the rates, and the likelihood that the contractor will be a nonprofit agency with limited capital reserves, most child welfare risk-based contracts also include mechanisms to ensure that contractors remain solvent and stable. The most common mechanism in child welfare initiatives is a risk-reward corridor. In addition to protecting contractors from excessive loss, the purchaser may also limit the contractor's ability to retain profits or savings.

Child welfare purchasers have found other methods of limiting a contractor's risk. For example, some child welfare case rates cover certain services typically reimbursed under Title IV-E funds, but the contractor is expected to bill Medicaid under fee-for- service arrangements to supplement the case rate. Or, in an attempt to better match level of risk to level of need, purchasers might propose risk- adjusted or stratified rates for children with different levels of service needs. Using a similar logic, in a few initiatives the purchaser allows the contractor to be reimbursed outside the risk arrangement on a fee-for-service basis for a certain number of children.

Finding

The majority of contracts that include financial risks for private child welfare agencies also have some mechanisms to limit risks.

In some instances, the contract includes aggregate or individual stop-loss provisions that limit the contractor's losses when expenditures exceed a certain amount for an individual child or for the entire covered population. Another method that is infrequently used in child welfare is a risk pool that can be accessed to cover unexpected costs under specified circumstances. The degree of exposure to risk and the potential for reward can also change over time within the same initiative.

Pricing the System and Adjusting the Rates

Child welfare initiatives have varied in their approaches to pricing the overall system, establishing rates for contractors, timing the introduction of financial risk, and adjusting rates over time. Some child welfare initiatives introduced financial risk during the initial implementation; others phased-in risk after some period of time—often after the first year of cost and utilization data collection and analysis. In some initiatives, the public agency allowed the competitive bidding process to set the price and establish the rates. In other initiatives, the rate was specified in the RFP.

Finding

In child welfare contracts, initial rates have often been developed with inadequate data or risk modeling tools. It appears when rates change based on actual costs the change is more likely to result in increased rates for providers.

In most instances, the overall budget for the initiative is initially based upon estimates of what similar services cost under the traditional system. The risk-based rates are also calculated on the basis of rates paid under per diem and fee-for-service arrangements. Many respondents to the CWLA surveys reported difficulty in accessing accurate historic data to guide them in pricing the system or establishing the rates. For example, few child welfare agencies have had the ability to estimate with confidence the costs of serving a child from entry to exit from the system as a foundation for developing an episode of care case rate. As a result of the initial guesswork, it has

not been uncommon for states to err in pricing the overall initiative or in setting rates, with, at times, mid-course corrections being made.

Anecdotal evidence suggests that at times, rates are adjusted based on state or county fiscal or political factors that do not necessarily reflect evidence of the sufficiency of the rates. In other instances, the changes are made in response to fiscal audits or independent evaluations. For example, as a result of higher than expected expenditures after the privatization contracts were introduced, Kansas undertook an independent audit that revealed the following:[14]

- Start-up issues caused costs and lengths of services to be greater than anticipated. The auditors attributed many of the cost overruns to implementation problems, including difficulty attracting experienced social workers, larger numbers of referrals than expected, key infrastructure problems (including MIS development), and the individual learning curve of each provider.

- The largest variable in the overall cost of services was the type and amount of residential services used. The auditor noted that the renewed emphasis on family foster care appears to be reducing aggregate costs.

- The monthly cost was much greater than the bidders' projected estimates. The auditors estimated that cumulative costs were 65% higher than originally projected for foster care and 13.5% higher for adoption.

Kansas Abandons Case Rates

In February 2000, Kansas abandoned its episode of care case rate approach altogether and instituted a per-child, per-month capitated rate payment system. The Kansas Department stated the following to a legislative oversight committee with regard to the agency's decision to dismantle the case rate system:

"The financial review process created concerns regarding the viability of the case rate as the payment system for foster care. The primary concern was that the contractors did not have adequate control over when children returned home or moved to another permanency [arrangement] to manage their finances in such a payment system. This left the contractors in a situation where their financial risk could not be appropriately balanced with their case responsibility."

As a result of the under-estimation of costs and inadequate case rates, the Kansas foster care lead agencies experienced severe shortages in the first years of operation. By March 1999, one contractor (Kansas Children's Service League) had an operating deficit of $1 million; another (Kaw Valley Center) had a deficit of $6.5 million; and the third (United Methodist Youthville, which subsequently went into bankruptcy in June 2001 and since has reorganized) had a $7.5 million deficit. In an effort to address these issues, the Kansas legislature transferred approximately $50 million from the federal welfare-to-work program to foster care.[15]

Fiscal Assumptions and Actual Performance

While cost containment or the re-direction of resources may be among the goals of the child welfare initiatives, many of the respondents to CWLA surveys indicate that the risk-based features they have incorporated also mirror best practice in child welfare. In fact, fiscal and purchasing changes do not appear to reflect a shift in ideology but rather recognition of the power of financial incentives to change practice.

Although child welfare respondents have rarely indicated that containing or reducing overall child welfare costs is the principal goal of the initiative, most initiatives do, however, have expected budget neutrality and the redirection of resources to provide more appropriate services to more people with the same dollars. In most initiatives, there were built-in assumptions about what effect the proposed change would have on costs. CWLA survey respondents were asked to compare actual fiscal performance data (if available) to fiscal assumptions that were made when initiatives were designed. Based on child welfare respondents report, no one-to-one relationship was found between fiscal assumptions and performance. Some initiatives were not designed explicitly or intended to save money, but they have (Illinois, for example), whereas others were intended to be cost neutral and have, in fact, cost more (Kansas, for example). Only three states expected the initiative to cost more than the previous system, but fiscal performance data indicate that 10 initiatives cost more than the previous system. In some instances, States reported they were pleased with results because funds had been re-directed, enabling more children and families to receive services at the same or slightly more costs.

There is little in the way of comparative analysis of risk-based initiatives with different structural designs to indicate that one structural or financing model is superior to another or, for that matter, superior to traditional contract arrangements.

It is important, however, that a public agency fully understand the pros and cons of each type of risk-based option and the potential opportunities afforded by different structural designs before making decisions. Some of the issues that must be considered are fairly straightforward; others require a full appreciation of how all the design pieces need to fit together to achieve results. It is also important to recognize that the ultimate success of an initiative may relate to many factors separate from the structural model and the risk option chosen.

3. Summary & Commentary

What is clear across published reports is that there is broad interest in privatization; there is great variation in the scope of current initiatives (in terms of geographical reach, target population, the number of clients served, and structural design); there is variation in financing mechanisms but with a common thread that attempts to link improved performance to reimbursement amounts or payment schedules; there are different approaches to defining and monitoring results but most initiatives are focused on outcomes related to state and federal mandates; and, there are mixed findings as to actual success related to effectiveness and efficiency (costs).[16]

Overall, the child welfare privatization initiatives have been consistent in some aspects since they first emerged a decade ago. Public agencies are still partnering predominantly with nonprofit agencies. The driving forces have also been consistent but with a broader involvement of the legislature in more recent years. States appear to be focused on improving quality and are increasingly turning to independent evaluations to confirm results. Risk-sharing arrangements are commonplace, but with new twists that more directly link payment schedules or amounts to performance.

Every child welfare initiative has had to wrestle with basic design and procurement questions relating to the type of risk or results based financing arrangements that will be used and the types of organizations that will be allowed to participate in the bidding process. There appear to

be many reasons why some initiatives succeeded and were later expanded and others failed to achieve fiscal and programmatic goals and were dismantled. At times, plans failed because they had design flaws from the outset or because there was not a balance between expectations, authority for decisions, and resources. It is encouraging that many initiatives appear to focus on increasing family involvement, cultural competency, and wrap-around approaches to service planning and delivery. Less promising is the fact that many states and private agencies still struggle to track basic utilization, cost, and outcome data within child welfare and across other child-serving systems to analyze the effect of various privatization initiatives.

In the past few years, more initiatives have undergone fully independent evaluations. However, the evidence is mixed. For example, the University of South Florida's evaluation of twenty-eight Florida counties in which community-based care (CBC) was operational found great variability in the performance of the CBC sites on different indicators related to safety, permanency, and well-being, in part due to the different stages of the implementation process and in part due to the significant variability in their designs and the level of funding.[17] The overall conclusion about expenditures per child contained good news but also pointed to the need for patience in finding improved results. CBC and non-CBC counties experienced similar average expenditures per child for the first four years of CBC, but not for the last three years, where average expenditures per capita were lower for CBC counties than non-CBC counties. Additionally, CBC counties spent a lower proportion of their total budget on out-of-home care than non-CBC during FY 02-03. The Florida cost findings are similar to those of other independent evaluations, including the Colorado and Kansas evaluations.[18]

In regards to achieving specified outcomes, evidence is promising but still inconclusive in many areas. Again, the Florida evaluation found that the privatized CBC sites performed, for the most part, as well or better than the non-privatized sites. However, there was variability among the CBC sites with some performing far better than others on certain outcomes but poorly, in comparison, on others. The most difficult areas to improve were those areas that are most difficult for public agencies as well——namely, moving children safely into timely permanency without having an increase in re-entry or other undesirable outcomes.

Best Practices in Privatized Case Management Systems

Research studies have identified a number of promising approaches found in various types of privatization initiatives including the following:

- *Wraparound values/principles*. Many initiatives appear to be grounded in system of care principles. For example, the majority of the Florida Community-based Care plans described an approach to case planning and services delivery that reflects core values of cultural competence, family involvement, and individualized plans that addressed identified needs.

- *Family team conferencing*. The majority of initiatives that have included privatized case management require the contractor to use a shared family decision making model to develop and revise case plans. Many initiatives include standards and timeframes for convening teams and completing and revising plans. Providers are monitored to ensure that providers are meeting standards.

- *Evidence-based practices & decision support tools*. A few initiatives have specified a particular practice that the contractor is required to use (MST, for example). More often, the contractor has had to describe the clinical protocols or decision support tools that would be used to ensure quality and appropriate, individualized services. The public agency typically signs off on protocols before implementation.

- *Continuity in case managers*. Under traditional child welfare systems, it is not uncommon for a child and family to have different caseworkers depending on the services and case plan goals. For example, a child might have one caseworker if services are provided in- home and then be assigned a different caseworker if placement is required. If the goal becomes adoption, a different caseworker might take over the case. Under many of the new initiatives, a single case manager (or a case management team) is assigned to the case and the same caseworker retains responsibility from the time of assignment until achievement of permanency and case closure. Specialists might be assigned to assist the worker (adoption or independent living specialists, for example), but the child and family experience continuity in case management from entry to exit. This model is the dominant model in Florida.

- *National accreditation standards*. A number of states require contractors to be accredited by a national accrediting body (COA, CARF, JACHO) and they mandate that nationally recognized caseload standards be met. (It is not clear in some cases that the funding is sufficient to support the required caseload standards.) Florida, Kansas, Missouri, and Illinois, for example, require accreditation.

- *Expanded services through community service networks*. An explicit goal in nearly half of the initiatives described by CWLA was to expand the current array of services available to children and their families through the creation of a provider network. Often, the public agency specified the services and supports that had to be included in the network but allowed the contractor flexibility in developing network standards and contracts with service providers. In some instances, the private agency that is responsible for case management is also responsible for network development. In other instances, the case management agencies and agencies responsible for network development are different and are linked by contracts or interagency agreements.

- *Improved use of technology*. As noted previously, while many initiatives still struggle to build and maintain adequate IT, many have built capacity that has resulted in improved data collection and use of data at the case level and as a guide for future system improvements. With better data on outcomes and costs, many initiatives have succeeded in getting additional support from legislators.

- *Added training and supports for caregivers*. Many initiatives have given extra attention to recruiting and supporting caregivers (foster, adoptive, and kinship families). Many have added formal and informal supports, including additional respite, bonuses for recruiting other families, mentors or resource families for new families, and networking/communications mechanisms.

In summary, while privatization may offer real opportunities to improve results, the development and implementation of these arrangements present a host of challenges.

Challenges[19]

As part of a project to assist the Arizona Department of Economic Security in weighing privatization options, in September 2005 interviews were conducted with private agency child welfare executives responsible for different types of case management services in five states. The sites were selected to represent the most common types of initiatives described in previous studies—namely, those involving case management and services for children and youth in or at risk of out-of-home care and those with adoption as a permanency goal. The interviewees noted a number of challenges that were similar across the different projects and consistent with national research including the following:

- *Inadequate data collection and analysis capability*. Data are needed to guide decisions about the structure, programmatic directions, and financing methods; to develop appropriate outcomes and benchmarks; to assess whether those outcomes/benchmarks are being met; and to make decisions regarding needed changes. Typically, neither the information systems nor the data they produce are adequate for the public purchaser or for the contract providers, especially those operating under risk-based contracts. Data collection and analysis was an area of concern for three of the five agencies interviewed (MS, FL, KS).

- *Lack of role clarity between private agency case managers and public agency staff*. Public agencies do not relinquish legal responsibilities when they enter into contracts. It has been difficult in many initiatives to find the right balance in public and private agency roles and responsibilities. Efficiency has been undermined because the public and private sector roles were not clear or were duplicative. Private agencies have been placed in untenable positions under risk-based contracts when they do not have control over key decisions that impact risk. This issue was raised by four of the five interviewees (MA, MO, OH, and KS).

- *Inadequate service capacity*. Without adequate and appropriate services, privatization is not likely to achieve, safety, permanency, or well-being goals regardless of the management, contracting, or financing model. Yet, in many cases, the contractor has not had the authority or resources to fill service gaps that pre-dated the initiative. Resources outside of traditional child welfare funding sources are often needed to build the capacity needed. Lack of service capacity was an issue for four of the five interviewees (MA, MO, OH, FL).

- *Poorly defined or the wrong outcomes*. The importance of outcomes in privatization efforts has been emphasized consistently. However, it is not always evident that outcomes included in contracts are the *right* ones or that they are defined in ways that are meaningful or measurable. Challenges related to outcomes were raised by three of the five states (MA, MO, Fl).

- *Resources that are not aligned with expectations*. When public agencies develop their privatization plans, the performance expectations are often higher than performance in the current system, while the resources are the same or less, making it difficult to achieve either programmatic or fiscal goals. This struggle was of concern to two of the five interviewees (MO, KS).

- *Problems with financing*. Significant variation exists in financing arrangements, with various

approaches to pricing the initiative, establishing rates, timing the introduction of financial risk, and adjusting rates over time. Issues arise in relation to the underlying sources of funding, the fiscal methodology, and the mechanisms to address the potential impact of risk-sharing. After a decade of experimentation, there is still no compelling evidence of the efficacy of one financing approach over another. Recent evidence might indicate that the dominance of the case rate may be giving way to other performance-based contracting options. Challenges related to financing were raised all interviewees.

- *Lack of private agency expertise in family-centered practices, evidence-based innovations, or new business processes*. A downfall of many initiatives is the lack of knowledge or experience of the private agencies in managing risk, creating provider networks, introducing appropriate utilization management, adapting and using protocols and decision support tools to better match services to needs and improve services, and meeting the requirements of legal mandates that are at the heart of child welfare case management. Program and business expertise was an issue for all of the executives interviewed.

- *No magic bullet for staffing*. Private contractors have had to come to terms with the same challenges the public agency faces -- namely the difficulty recruiting, supporting, and retaining workers and caregivers. Three of the five executives raised this as a primary concern.

- *Lack of understanding of legal issues and experience engaging the courts*. Significant difficulties have arisen when privatization plans failed to recognize the need for judicial buy-in. Court-related issues are especially important for public agencies to consider when balancing the level of risk with the degree of autonomy contractors have in decisions that affect risk. The Kansas experience with the initial launch of privatization should have been a clear warning for other States. Unfortunately, this issue continues to be a challenge in many initiatives. In other initiatives, as noted in the case studies, even though the case management is privatized, many states have ensured that the public agency's legal staff remain in place and in some instances, the public agency staff attend hearings with the private agency case managers.

Various researchers using different methodologies have identified additional challenges, including the following:

- *Limited funding sources fail to meet complex needs*. Despite the higher prevalence of poor physical health and mental health and substance abuse issues among children and families, many privatization contracts are funded primarily with child welfare funds and have failed to include arrangements for accessing health, dental, and behavioral health services that fall outside the contract. This funding issue has been a challenge for Florida CBC agencies and the solutions have varied.

- *Adherence to rigid procedures*. By accident or design, some projects have struggled because there were inherent barriers to innovation. Contracts often require adherence to day-to-day operating procedures required of public agency staff that were not flexible enough to allow contractors to succeed. Simply changing from a public agency to a private agency will not result in improved outcomes or efficiencies.

- *Flawed contracts*. In many initiatives, the RFPs and contracts are fraught with problems. In some cases, expectations are framed in ambiguous terms, making it impossible to determine what the private agencies were expected to do, what clients were expected to receive, and what results were to be produced. According to Madelyn Freundlich, "In sum, in many privatization initiatives, the dynamic was one of an inexperienced purchasing agent attempting to develop at-risk contracts with inexperienced sellers."[20]

- *Overdone or underdone monitoring*. Most public agencies have struggled to find the appropriate level of monitoring and oversight. Researchers have noted a tendency for micro-management in some initiatives, while in other initiatives, the level of monitoring seems woefully inadequate. Over time, the public and private agencies in many Florida CBC sites have struck an appropriate balance and have created some promising practices that merit further study. The HFC case example in Appendix 1 describes the model used.

- *Limited consumer involvement*. Organizations that have studied the essential features of privatization consistently have highlighted the importance of consumer involvement. Though it is a value articulated in most RFPs and contracts, it is unclear whether (and how) consumer involvement is actually occurring in the planning, implementation, monitoring, or evaluation of child welfare privatization.

- *Lack of attention to cultural & linguistic competence*. Nationally, systems of care for children are attempting to respond effectively to the needs of children and families from culturally and linguistically diverse groups. Again, though a principle in all child welfare policies, it is unclear whether cultural and linguistic competence is being considered or is improving under child welfare privatization. Attention to cultural competence and engagement of the Indian Tribal Councils would be particularly important in States with large native American populations.

Lessons Learned & Advice from the Field

As depicted in Table 1, the structured interview protocol for private agency executives in five States asked the executives to prioritize the most important issues for both public and private agencies to consider in planning for a privatized case management system.

Table 1: Advice from the Field

Initiatives	Advice
What are the top three things public agencies should consider in contracting for case management?	
Massachusetts Commonworks	1. If both public workers and private agency case managers have case management responsibilities, make sure there is clarity in public and private roles. 2. Make certain that the public agency retains the responsibility for legal services. 3. Include fiscal incentives aligned with results -- but make sure you have IT and quality assurance capacity to monitor both costs and outcomes.

Initiatives	Advice
Missouri Interdepartmental Initiative	1. Build a real partnership with the private sector to get the political clout needed for hard times. 2. Make sure the financing option gives flexibility in funding and specifies the outcomes/results desired. 3. Require accreditation as an added protection for quality.
Cuyahoga County, OH. *Case Rate Pilot*	1. Get "buy in" from all levels of the public agency staff. 2. Clearly define roles and responsibilities between the county staff and the case management organization. 3. Have mechanisms to avoid and manage the risk of abuse and neglect of children while in the system.
Florida Lead Agency Heartland for Children	1. The importance of data accuracy, accessibility, and integrity. 2. The complexity of financial reporting (merging governmental accounting into traditional non-profit accounting systems). 3. The importance of strong leadership and the requirement of critical, analytical thinking to ensure viability of the lead agency.
Kansas Privatized Adoption, foster care, and in-home	1. The impact on federal requirements for documentation. 2. Knowledge of expenses (including direct and indirect costs) 3. A plan to develop "buy-in" from all stakeholders
What are the top three things private agencies should consider in developing the capacity to provide case management services?	
Massachusetts Commonworks	1. Look at this as an opportunity but also recognize what you don't know and hire the people who know case management from the public agency perspective. 2. Look at staffing: recruitment, training, and then build capacity to respond to the public agency's need for immediate responses. 3. Have an attorney review liability issues and prepare the Board.
Missouri Interdepartmental Initiative	1. First, they need to build the expertise. Start by hiring experts to guide them through all they don't know about the system's obstacles. 2. Get a handle on costs and if the money isn't there, don't bid. 3. Philosophy of care. Many providers will need to embrace family-centered practices, build child/family strengths that will help to achieve permanency, while also acquiring new business tools & skills.
Cuyahoga County, OH. *Case Rate Pilot*	1. Make sure that they have enough referrals that fit the project criteria -- Is the target population big enough? 2. Understand risk. Risk can be created by actions outside of the control of the case manager (*ie*: court, school). 3. Make sure they have the services that will meet the needs of the population that will be included.

Initiatives	Advice
Florida Lead Agency *Heartland for Children*	1. Prevention capacity- Prevention is an investment strategy. When properly administered, it will realize cost avoidance. 2. Service capacity- Utilization Management is a core business strategy in the system of care to manage resources, increase choice and promote cost efficiency. 3. System capacity- A true "system" of care includes the best characteristics of structure, process, subsystems, information, growth and integration.
Kansas *Privatization of foster care, in- home, and adoptions*	1. The private agency needs to have an MIS system that captures the type of data that is needed to track cases and provide fiscal and other management reports. 2. A utilization management system which authorizations of all out of home placement and services and payment. 3. Be prepared to pay mid-level managers higher than average salaries.

Key Success Elements

Based upon national research findings and the interviews with private agency executives, key factors for success, across different designs, appear to relate to the sophistication of the purchaser in planning, procurement, and contract oversight; the alignment of resources with expectations; the adequacy of funding and contractor rates; the buy-in from stakeholders; the care with which system designs were developed; the clarity and appropriateness of the expected outcomes; and the infrastructure, leadership, and innovation of the contractor and the public purchaser. Successful privatization initiatives share a few essential characteristics in common with effective public agency programs:

- Strong and steady leadership
- Clear vision, goals, objectives, and performance criteria.
- Sufficient staffing and other resources to implement the vision
- Continuous and meaningful performance monitoring
- Specific, measurable outcomes
- State-of-the-art information systems that allow private and public service providers to track progress and outcomes
- Strong and committed leadership
- Resilient interpersonal working relationships between public and private agencies
- Strong ties to the communities they serve
- New business tools and innovative practices.

It seems clear that privatization is best implemented through a broad-based planning process that engages stakeholders in a sustained dialogue for the purpose of reaching consensus on the goals of the privatization initiative. Reaching agreement on difficult decisions later in the planning process will be far easier if all parities are united in a shared vision.

At the outset of planning for privatization, it is also important for policymakers and decision makers to recognize that positive results will not be immediately evident. States should not expect to save money through privatization –– at least not in the short-term. Greater efficiency and improved outcomes for children and families will not be achieved simply because private agencies assume primary responsibility for case management but rather because all of the agencies involved are committed to working together over the long haul to identify and remove barriers that stand in the way of achieving their shared vision.

Privatization Continues to Evolve

While the previously described national trends information accurately reflects research on initiatives that were underway at the time the studies were conducted, it is important to note that initiatives are not static. Changes may be made in financing arrangements or in the overall design of an initiative when it becomes clear that the contractor does not have control over the factors that result in unacceptable risks or when results are not as expected. As states and contract agencies fully assess the costs and benefits of their financing and contracting arrangements, it is not unusual for State and local initiatives to alter their initial plans. Some initiatives that were included in the CWLA 2000-2001 survey report, for example, have made significant changes in various aspects of the model subsequent to the 2003 report. Several initiatives, selected from the 39 described in the CWLA report, are highlighted to illustrate the types of shifts that have occurred:

- ◊ In Missouri, child welfare functions are the responsibility of the Division of Family Services (DFS) of the state Department of Social Services (DSS). DSS also includes the Division of Medical Services (Medicaid) and the Division of Youth Services (DYS) for juvenile corrections. There is a separate Department of Mental Health (DMH). In 1997, the then-Directors of DSS and DMH formed the Interdepartmental Initiative for Children with Severe Needs with funding from The Robert Wood Johnson Foundation, the Center for Health Care Strategies, and pooled funding from dollars provided by DSS and DMH. At the end of the original contract period (February 2002), two of the original Initiative agency partners elected not to participate in the contract extensions. DMH, citing budget difficulties, withdrew, as did DYS, which believed that it already provided the services provided by the lead agency. These developments occurred shortly after the departure of the DSS and DMH Directors who were responsible for the creation of the Initiative.[21] While the initiative continues with the original contractor (through six contract extensions), the blended funding is now reduced to Medicaid and child welfare funds. The contract is due to expire at the end of 2005 and with a new performance-based contract reform underway, the future of the Interdepartmental Initiative is unclear. It appears that in the latest privatization effort in Missouri, the State has taken core elements from the previously described Illinois model.

- ◊ In Hamilton County, Ohio, an inadequate case rate caused the contractor (Beech Acres) to use its own endowment to subsidize (more than $ 10 million) an interdepartmental system of care initiative that targeted cross-system children with complex needs. At the time of renewal, Beech Acres' refusal to accept a continuation of what it believed was an inadequate case rate ultimately led to termination of contract re-negotiations.[22] The county re-bid the initiative and a new provider (from out-of-state) took over the contract.

- ◊ The Franklin County, Ohio Children Services Project was based on the Franklin County Children Services (FCCS) agency agreement with the county Alcohol, Drug Abuse, and Mental Health (ADAMH) Board and was intended to facilitate better access to behavioral health services by children and families in the child welfare system. The agreement fell apart in 2002. Several reasons were given for the termination of the ADAMH agreement. Among other issues, a recent case study, cited ongoing underfunding of the ADAMH Board and the arrival of a new ADAMH director who did not support the agreement.[23]

- ◊ The Permanency Achieved Through Coordinated Efforts (Project PACE) initiative in Texas, managed by the Lena Pope Home, targeted children with therapeutic needs and their siblings who entered the foster care system from counties that surround Fort Worth. At the time of the CWLA survey, the contractor was expecting to serve approximately 500 children with a budget of approximately $14M under a fixed rate contract of $77/day per child, regardless of the level of out-of-home care. The project was dismantled shortly after the CWLA survey report was published. More recently, in 2004, Governor Rick Perry declared the condition of the system an emergency issue and called upon the 79th Legislature to act decisively to provide the resources and reforms. Senate Bill 6 established a framework for reform by requiring among other things that the Department to privatize substitute care and case management services.[24]

- ◊ The *Commonworks* initiative in Massachusetts was one of the earliest case rate lead agency models that served children with intensive needs. The original financing was no-risk for 18 months to allow the agencies and the State to track actual costs and outcomes. The case rate that was introduced was based upon that assessment. In recent months, *Commonworks* has been dissolved and absorbed by a new initiative. The previous case rate (that also included bonuses and penalties) has been abandoned for a non-risk cost- reimbursement model solely for case management services, with direct services being reimbursed by the State agency. (The model is described in Appendix 1)

It is unknown how many other initiatives reported by CWLA or other research projects have modified their original privatization project. Some of the early initiatives were abandoned due to changes in the State's overall priorities, changes in leadership, or a natural evolution brought about by increased knowledge about what worked and what did not. Some initiatives introduced strategies to ensure sustainability in the face of leadership changes or economic downturns, including creating legislatively mandated bodies to oversee the initiatives, serve as a voice for the community, and identify and access the resources needed to support the initiative. Florida is a good example.

Community Alliances In Florida

Community Alliances are charged by statute with a number of responsibilities including local needs assessment and establishment of priorities; determining outcome goals; serving as a catalyst for resource development; advocacy; and promoting prevention and early intervention services. (Florida Statute §20.196[b]).

Research has helped to identify both promising approaches and challenges in various current initiatives across the country. However, it is important to recognize that privatization is continuing to evolve and with each evolution there are new lessons to be learned.

A Framework for Decision Makers

This section provides a framework that is intended to be a technical assistance resource for policymakers, administrators, and stakeholders to use in weighing any child welfare case management privatization options.

If the intent of any potential child welfare privatization of case management is improved results and cost efficiency, significant energy will need to be devoted to planning the effort and to overcoming the previously described challenges. The following ten principles provide guidance and raise issues that merit consideration by planners and decision makers who are weighing privatization efforts.

1. View Privatization As A best Practice Strategy

In far too many States, fiscal and contract reforms are treated as discrete, isolated efforts and not as an integral part of the State's overall approach to system improvement. Often, inadequate staff resources are committed to the planning phase. Planning for best practice takes time and the process needs to acknowledge - and expect - that public agency staff and providers will need time to plan and prepare for any potential privatization of case management.

As public agencies examine options for privatization, it will be important to ensure that current improvement efforts are the foundation for future privatization. Any privatization plans that emerge should be supportive of and consistent with other State reform goals, strategies and initiatives.

The public agency will need to identify key internal staff to guide the effort and develop the infrastructure to support an inclusive planning process that engages external stakeholders throughout the planning and implementation.

Is the consideration of privatization taking place in the context of other State improvement efforts?

Is there an infrastructure to support planning?

How will Stakeholders be involved?

What resources will be required for planning?

How will planning decisions be communicated internally and to the field?

How long should the planning take before there is a "plan?"?

2. Define Success

Stakeholders will want to know whether the privatization effort worked to improve performance. That should be a straightforward question with a clear-cut answer. In many initiatives across the country, it isn't. For example, in a comparison of contracts with four of the Florida community based care agencies: one contract had 47 outcome measures, two contracts had seven, and one contract had nine. No contract directly stated what the overall measure of success would be. From the outset of planning, it would be important for the public agency, provider agencies, and external stakeholders to agree on the overall

What does the State hope to achieve through privatization of case management?

What are the overarching goals and how will success be defined and measured?

How will results be communicated?

purpose and what constitutes success; define common performance requirements and child and family outcomes that will be used as indicators of success; and report performance on the same indicators over time. Unless this occurs the State will never be able to say conclusively whether privatization of case management was a success.

In weighing options for privatization and establishing broad goals, planners would need to rely upon current performance data and information gathered through the focus groups, surveys, and interviews to identify potential avenues where privatization could enhance strengths or remedy deficits. In setting performance targets and desired outcomes, it is important to start with a realistic assessment of current performance. The public agency has to have the capacity to generate performance reports on core permanency, safety, and well-being outcomes. The data in these reports will be critical as planners establish a baseline on which to build.

3. Have a Clear Rationale for Selecting the Target Population and the Case Management Model

As noted previously, no State has chosen to privatize the Hotline or CPS initial investigation functions.

Based upon national trends over the past decade, the more likely opportunities lie in the areas of out-of-home care, in- home services, independent living, adoption, and adoption subsidies. The choice of target population and the focus of privatization must be based not only on stakeholders' views but also on a host of other factors.

Planners should weigh privatization in relation to current initiatives, asking: Is there a role for privatized case management that would add value to the initiative and to the broader system improvement effort? The current performance of the public agency should be evaluated to identify places where a new approach could perhaps produce better results. That assessment should be done before final decisions are made.

There is no one "right" choice. Importantly, however, the decisions that are made about the target population for privatized case management should drive decisions about the services beyond case management that need to be included in the initiative. The impact of these decisions make the need for a clearly stated rationale regarding target population all the more important.

Once the target population and focus are clear, the State will still need to decide the size of the population to be served and the geographic area(s) for the initiative. The initiative could be Statewide, with some

Which children and families should be included?

- o Children in foster care or only those in therapeutic levels of care?
- o Children under age 6 or older youth in transition?
- o Children served in-home?
- o Children with adoption as a permanency goal?
- o Children in the care of relatives?
- o A portion of some or all children in the current caseload or only new referrals?

Will the initiative be statewide or limited to a geographic region?

Will it be phased in over time, or all at once?

Is a pilot the right way to go?

What are the pros and cons of performance-based single agency contracts versus lead agencies?

Are there other hybrid models that could be developed?

What are the capacities, limitations, and interests of providers in different structural and fiscal models?

level of flexibility for regional differences, and could be implemented through a gradual statewide phase-in or through a single pilot in one or more regions of the State. Stakeholders urged a cautious implementation approach, suggesting one (or more) pilots in several regions to demonstrate effectiveness over time with services provided to children and families residing in both urban and rural areas.

4. Define Roles

Role clarity has been a prevailing concern for both public agencies and their contract providers in privatization efforts across the country.

Some States have chosen a "dual" case management model in which public agency staff retain responsibility for certain functions while delegating responsibility for other decisions to the private agency.

Other initiatives provide contract oversight but delegate total control over key decisions to private agencies. Some initiatives start with one model and evolve over time into something different.

Some States define the case management approach, including specific caseload standards. Others have allowed private agencies the flexibility to define their approach, with the understanding that State and federal requirements and a limited number of performance standards will be met.

Who will develop and revise the case plan?

Who will handle court-related petitions and hearings?

At what point will the referral be made to the private agency?

Will it be a "no reject, no eject" system?

Who makes decisions about placement, level of care, permanency goals, and case closure?

At what point will the provider's responsibility for the case end -- at the time of permanency or for some period of time thereafter?

If the child returns to care, will the same agency pick up the case?

In cases of disagreement, who has ultimate authority?

What problem-solving mechanisms and dispute resolution processes will be needed?

5. Ensure Service Capacity

When broad goals, target population(s), and roles are defined, it will be important to specify which services and supports will be available to the private case management agency, including the responsibility or authority they will have for fillings gaps in service availability prior to assuming case management duties.

One of the reported benefits of the lead agency model has been the expansion of both traditional and non- traditional services. If service expansion is to occur, flexible funds will be required and adequate time will be needed

Given the proposed geographic scope and target population, what is the current service capacity?

What authority/funds will be provided to allow the private agency to stimulate the development of services?

What impact would a privatized case management system have on access to services to meet the child's mental health, health, dental, and education needs?

How would privatized case management affect existing service contracts?

by the private agency to create a provider network that is linked to other services, included health and behavioral health care.

Some initiatives have included limited funds and time as *start-up* to allow either the public agency or private contractor to expand services prior to the start of the privatized case management system. When funding and time for *start-up* are not built into the implementation, initiatives have encountered serious fiscal and programmatic challenges.

Service capacity may be of particular concern to rural stakeholders who might question how a privatized case management approach could work in the absence of an array of services that children and families need. The public agency needs to work with stakeholders and build into any privatization plan a recognition of and plans for meeting gaps in service capacity and eliminating access barriers.

6. Design and Implement a QA/QI and Contract Monitoring System

> How will the public agency monitor contracts to support innovation while safeguarding children?
>
> What enhancements in monitoring and QA/QI will be needed to effectively monitor these types of contracts?
>
> How much will it cost to make needed improvements?
>
> Will national standards be used to shape the approach to the monitoring process?
>
> Are there current regulations, policies, or statutes that need to be reviewed/revised to support a new approach to monitoring or to allow for a new financing approach?

As noted in Part 1 of this report, numerous research studies have revealed an inconsistent, inadequate or inappropriate approach to monitoring across privatization initiatives. In some initiatives private providers were not held accountable for the results that they were expected to achieve nor were they rewarded for good performance.

When initiatives across the country have worked to establish an effective monitoring system, disagreement commonly has arisen around the definition of results and the means of ensuring the validity of data that indicate whether results were or were not achieved. In the early days of CBC implementation in Florida, for example, CBC agencies voiced concern in some sites that frequent reporting of data was required on too many and not always meaningful indicators. The lead agencies were subject to periodic (and at times, too frequent) onsite quality assurance reviews by state or local Department staff. Some CBC contracts required quarterly quality assurance reviews by the local Department office, four internal quality assurance reports, at least one administrative review, a minimum of six licensing reviews, an annual evaluation, an independent audit, preparation for national accreditation, daily entry of data, monthly reports including reconciliation of all expenditures.[26]

Over time, many Florida sites and other privatization initiatives have found a balance that allows the public purchaser to monitor for results while also granting the provider the flexibility to innovate. Many performance-based contract initiatives now combine monthly or quarterly Desk Reviews that are focused on results rather than process with a limited number of onsite visits that look in-depth at a random sample of cases, following a methodology similar to the federal review process for States (data analysis, record reviews, and interviews). Finally, an increasing number of initiatives are requiring national accreditation for providers as added insurance that

the provider has the capacity to ensure a consistent quality of care. Meeting nationally accepted standards is one of the most effective means of ensuring overall quality of a system.

Planners need to carefully think through the monitoring process, drawing on the "lessons learned" from other communities that have struggled with finding the right balance and developing standards and quality assurance processes that promote contract compliance and the private agencies' achievement of defined results without stifling the provider's ability to innovate.

7. Assess Data Technology Needs

Most researchers have noted that privatized initiatives have placed a premium on access to real time information to guide case-level decisions and system planning. However, there is abundant evidence that many initiatives have lacked the technology or staff resources to collect or manage data. Both public agencies and providers need data for operational decisions and successful contract management. The MIS must be able to track performance from a variety of different perspectives ñ client status, service utilization, service/episode costs linked with case plan goals, treatment, and outcomes. The system must be need-driven, flexible, user-friendly, and capable of generating useful reports for all users.

Additionally, at the case level, when private agencies assume case management responsibilities they are often allowed or required to enter data directly into the State's SACWIS. When private agencies have this requirement, they have often had to develop complex and dual entry mechanisms—running their own management information systems to manage their business processes and separately entering data into State systems to meet contract requirements–hardly an ideal or cost-effective solution. Additionally, few State data systems are equipped for utilization management, provider network management, or claims/billing/ reconciliation/and payments—all core functions of some privatization contracts.

What are the implications for the public agency's data systems and the collection and use of data?

Will private agency case managers enter data directly into the State's information system? If not, how will the public agency ensure compliance with all federal and state data reporting requirements and maintain a single case record?

What MIS enhancements are required to obtain the real- time information needed to manage and evaluate the system?

What will technology enhancements cost?

What capacity must providers have?

How will the public agency verify the integrity of data entered by providers?

How will data be used to monitor contracts?

How will data be used to guide future planning?

Planners of any privatized case management contract will need to assess the current IT capacity of the public agency and identify enhancements that may be required. They will need to ensure that contract agencies have the technological and human resource capacity to meet specified data collection and reporting requirements.

8. Identify Funding Sources and Financing Options

According to the most recent CWLA 50-state survey of child welfare financing trends, half of the states are now testing new methods of financing child welfare contracts. In the best-case scenario, these new reforms have increased flexibility and more closely aligned fiscal incentives with programmatic goals, resulting in better outcomes for children and families. Best-case scenarios, however, do not happen automatically.

Most child welfare privatization efforts are supported primarily by child welfare funds, but States are increasingly using funds outside of child welfare to better address the complex needs of the children and families served.

Planners will need to identify funding sources and establish linkages with other child serving systems (such as mental health, substance abuse and Medicaid) for the provision of services that will not be reimbursed directly to the provider.

If the child welfare system does not have a set aside pool of Medicaid funds to pay for therapeutic placements and services, it is essential that mechanisms be in place to ensure that child and family needs are being met through the State's health and behavioral health care plans.

Most privatized initiatives introduce some elements of financial risk. Risk-based contracts require providers to have the infrastructure, knowledge, and skills to consistently assess and meet the needs of the children and families they serve while managing resources to achieve fiscal goals.

What are the budget assumptions—that privatization will save money? Redirect money? Serve more people for same money? Improve quality but cost more money?

What are the funding sources and amounts that can be included?

Based on the available funds, scope, expectations, and provider capacities, what are the pros and cons of the various risk-based or other contracting options that offer financial incentives?

How will control over key decisions be balanced with the level of risk assumed?

How will the financing arrangement provide flexibility regarding resources?

Will risk be phased-in or introduced from the outset?

What mechanisms can best protect against loss? Will contracts limit profits/savings?

How can the payment schedule be structured to enhance programmatic and fiscal goals?

Will the funding be sufficient to support national caseload standards?

What will the impact be on federal revenue and overall state budget?

What are the anticipated start-up costs?

Prior to determining whether risk-based options are desirable or which risk-based financing option the public agency might use, it is important for planners to assess current provider capacity and to carefully explore the pros and cons of different models with that capacity and interest in mind. It is equally important to the public agency's comfort level in relinquishing control over some decisions in return for the introduction of financial risk. It is unrealistic to

embrace a full or partial risk contract and assume that current roles and responsibilities will remain intact.

9. Consider Staffing and Training Issues

In the past several years, the nationwide staffing crisis for both public and private child welfare agencies has become a well-documented and difficult to remedy reality. For that reason alone, it is important to acknowledge that any move towards privatization of case management may negatively impact the ability of the public agency to recruit and retain workers.

The degree of anxiety and frustration expressed by public agency staff at the mention of privatization can be striking and disturbing. As one staff member in a focus group in Arizona pointed out pointed out, "It is naive to assume that discussions about privatization will not negatively affect staff morale at a time when we are already overworked, underpaid, and under-valued."

It is essential for planners to recognize that the discussions about privatization, regardless of the outcome, are likely to increase anxiety of the public agency staff. It is imperative that staff be engaged in any planning effort and that the State have a communications plan in place to ensure that timely and accurate information is disseminated as decisions are made.

Issues related to salaries, benefits, pensions, staff qualifications, and training will need to be addressed by planners as they weigh various privatization options.

Private agencies will need to be engaged to ensure that they fully understand the challenges in recruiting, retaining qualified staff. Contracts should allow and encourage the private sector to introduce innovations or supports that might address current staff retention problems.

What impact might the change have on public and private agency staff recruitment and retention?

What is the plan for communicating internally and externally to minimize misinformation?

What are the training implications for both public and private agency staff?

Will the public agency be able to capture IV-E training funds to prepare private agency case managers?

Will the public agency require private case managers to complete required training?

Will the public agency set the standards for case manager qualifications or will providers be at liberty to set their own standards?

Will the contracts include increased expectations and standards for child/family contact and visitation or other performance standards?

Will the contracts propose national workload/caseload standards consistent with national accreditation? If so, are the funds adequate to support the caseloads?

10. Chart A Course From Planning to Implementation

Finally, if a decision is made to launch a privatization initiative, the public agency will need to finalize design elements and determine the best course for translating the vision into a solid procurement and implementation plan.

It will be important for the Request for Proposal (RFP) to describe in detail the purpose of the contract; the expected outcomes and deliverables; performance standards; methods for payment, including provisions for any bonuses or penalties; the responsibilities of the contractor, the public agency, and any other partnering agencies; and the mechanisms that will be used to monitor contract compliance and attainment of goals.

The public agency will need to develop a clear plan for implementation, evaluation, and continual refinement as changes are proposed and made. The detailed transition plan would need to address the impact on current public agency operations (including staff retention), and the additional supports, if any, that might be needed in the short term to support implementation.

If national studies are an indication, it is likely that approaches to financial risk, performance standards, and outcomes may evolve over time with increased knowledge and experience. Under the best-case scenario, these changes will occur as part of a continuous quality review and improvement process.

If an RFP is issued, who will be allowed to bid -- nonprofit firms or proprietary agencies as well? Existing individual provider agencies or newly created corporations comprised of multiple partners?

Are there sufficient public agency staff resources to prepare the RFP?

How will the solicitation and review process be managed?

How will proposals be evaluated and best value be determined?

Will there be a start-up phase to allow contractor(s) and the public agency to build capacity? If so, will there be funds to support start-up?

How will the transition be staged to minimize disruptions for children, families, and caregivers?

What is a reasonable timeline from selection of contractor(s) to full implementation?

Throughout the planning, the public agency will need to determine the best means of engaging local public offices, providers, and community stakeholders in the planning, without jeopardizing the integrity of a competitive procurement.

Endnotes

[1] This document is adapted primarily from McCullough, C. (2003). Financing & Contracting Practices in Child Welfare Initiatives & Medicaid Managed Care: Similarities and Differences. CWLA: Washington, DC. Funded by the Center for Health Care Strategies.

[2] Freundlich, M. & Gerstenzang, S. (2003). An Assessment of the Privatization of Child Welfare Services. CWLA Press: Washington, DC. Email books@cwla.org.

[3] There have been several major research projects in recent years that have focused on management, finance and privatization changes occurring in state child welfare agencies across the nation. Studies include those conducted by the U. S. Government Accounting Office, the Child Welfare League of America (CWLA), George Washington University's study of contracting practices, a decade of reports of the Health Care Reform Tracking Project (HCRTP), which is a collaborative effort of the Research and Training Center for Children's Mental Health at the University of South Florida, the Human Service Collaborative of Washington, D.C. and the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development, and the previously cited Children's Rights study. All reports of the HCRTP are available from the Research and Training Center for Children's Mental Health, University of South Florida (813) 974-6271. Special analyses related to the child welfare population are available from the National Technical Assistance Center for Children's Mental Health at Georgetown University (202) 687-5000, deaconm@georgetown.edu. Information in this section draws from each of these efforts.

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[19] The challenges described were synthesized from the interviews with executives in five States and from research from the following sources: McCullough, C. & Schmitt, B. (2003); Freundlich, M. & Gerstenzang, S. (2003); McCarthy, J. & McCullough, C. (2003); GAO Mauery, R., Collins, J., McCarthy, J., McCullough, C., & Pires, S. (2003). Contracting for coordination of behavioral health services in privatized child welfare and Medicaid managed care. Center for Health Care Strategies, Inc.; and GAO (1998a and 1998b).

[20] Freundlich, M. & Gerstenzang, S. (2003)

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